Article

A community music therapy project's journey

Bethan Lee Shrubsole

ABSTRACT

Since starting the music therapy Community-Based Organisation (CBO) Music for Peaceful Minds (MPM) in July 2008 there have been on-going gradual but significant changes to the way music therapy is practised and spoken about worldwide that has both challenged and informed MPM's local practice in northern Uganda.

This paper is a personal reflection of MPM's work over the past seven years with an aim of explaining what it means to work as a music therapist with a community-driven frame of mind when working in places that need a flexibility of approach. How has this work moved away from conventional music therapy (where symptoms and health problems at an individual level are focussed on in a therapeutic space) (Stige 2002)? And how has MPM evolved alongside the music therapy profession's changes over the years since the emergence of community music therapy?

KEYWORDS

community music projects; Uganda; community music therapy

Bethan Lee Shrubsole set up the Music for Peaceful Minds (MPM) project in northern Uganda in 2008 and has been supervising its therapists since then. From 2011 until 2015 she worked as a music therapist in western Uganda, working with children with autism, Down's syndrome and hearing impairments in a government school. She now lives in Cambridge with her husband and two sons, working in schools around the county as a music therapist.

Email: musicforpeacefulminds@yahoo.co.uk

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INTRODUCTION

The aim of this paper is to share my experiences of starting the music therapy programme Music for Peaceful Minds (MPM) in northern Uganda whilst working through my own confusion about whether or not what I was doing was 'music therapy'. I also began to question whether or not it mattered if what I was doing was music therapy or a more community-centred music therapy. Some readers may wonder why I am struggling with the idea of community music therapy since discussions about it have been around since at least 2002. Aside from the fact that community music therapy is still an "emerging movement" (Stige 2014: 47), the answer is that none – or at least very little – of my training[1] focussed on community music therapy and in the first few years since graduating I did not come across much practice of community music therapy in my area of special needs work in the UK. During the seven years of running MPM in Uganda I met

[1] I studied a Masters in Music Therapy at Anglia Ruskin University, Cambridge, in 2006.

several practitioners (most of whom were newly qualified music therapists and some of whom were volunteers for the project) who had not heard of community music therapy, despite the amount of literature written on the subject. As the work I was doing in Uganda used to constantly go against a lot of what I considered were the 'rules' of music therapy (keeping confidentiality, having 'strict' boundaries of space and time, for example), I used to worry that the work I was doing in Uganda was not 'real' music therapy. So I decided that I would share MPM's work to encourage music therapists that community music therapy is happening all around us, giving us a new freedom to meet the needs of the communities in which we work.

I begin the paper by outlining some of the discussions about community music therapy so far and notice through my own interactions with music therapy colleagues that community music therapy, although it is not a new concept, is still not a common idea to some music therapists practising today. I then introduce the work of Music for Peaceful Minds (MPM) and explore how it has evolved since it started in 2008 by looking at some of the institutions that MPM works with in turn and describing each one's needs and therefore how MPM has had to negotiate various demands made by the institutions. The final section summarises MPM's journey and brings it in line with how the music therapy profession has evolved, and is still changing.

This paper is intended to inform music therapists about work that is being done in Uganda; I am English, and was working with Ugandans, and I know that working in cultures different to one's own can be confusing and challenging. My hope is that others who are starting similar endeavours can take ideas and encouragement from the struggles that I have been through and hopefully draw courage to work in the way that best fits their area of work. This paper is not claiming to be a research study or theoretical analysis, rather a personal reflection of one community music therapy project's journey.

CONTEXT

Recently I was reading some community music therapy literature and was particularly taken by music therapist Powell's (2004) piece of work in a residential home and day care centre for the elderly because she used the analogy that the residential home's community was married to music therapy and formed a reciprocal relationship. This equal relationship struck me because I had always thought of music therapy as being delivered to the community, not working in partnership with it. For Powell, working in the residential community necessitated flexibility in the way she worked, and she was able to link in aspects of her previous work as a community musician, which she describes as being

> "about inclusion and empowerment; about giving people a voice; about social interaction and often community action through the arts" (Powell 2004: 168).

She wrote that all the different aspects of her work in the residential home (individual, open groups, closed groups, performances and spontaneous groups) meant that her music therapy work had to evolve. It did so

> "in response to the varied and changing needs of individuals and the institutional community, developing beyond the more conventional therapeutic boundaries of time and space" (Powell 2004: 171).

This resonated with me because my work in Uganda has also needed to evolve. As founder of – and music therapist for[2] – Music for Peaceful Minds (MPM), a Community-Based Organisation (CBO) in northern Uganda, I have a similar outlook on how my understanding of conventional music therapy[3] had to evolve according to the context in which MPM works. MPM currently operates as a peripatetic music and art therapy service in Gulu, northern Uganda within a variety of institutions including special needs units and a juvenile detention centre. It exists to provide creativity and counselling for children in Ugandan institutions that otherwise may lack these services. (There is also a need for the counsellors to have an understanding of the primary or secondary trauma that the children may have experienced during the now-ended 25 year-long rebel war.) MPM offers creativity mainly in the form of play through art and music and the counselling happens as the arts counsellors[4] get to know the children and the

[2] I was a music therapist for MPM in 2008 and have since directed and supervised other MPM counsellors' work.

[3] What Ansdell (2002) describes as a 'consensual model' of music therapy, Stige (2002) refers to as 'conventional music therapy', a model that examines "symptoms and health problems at the level of the individual, to focus the interventions at the same level and to work within the boundaries of a therapeutic space".

[4] The practitioners are called 'counsellors' in order for their roles to be better understood locally and to respect the title of 'music

children in turn open up to them. MPM currently runs large open groups, both large and small closed groups and occasional workshops for parents and guardians of children with special needs.

According to Stige (2014), ideas about music therapy and communities have been emerging since the 1990s, but community music therapy really took off with Ansdell's article *Community Music Therapy and the Winds of Change* in 2002. Since the publication of this article there has been a growing desire, borne out of necessity, to redefine music therapy because it has evolved over the years of its professional existence and now shares some common ground with community music. The idea that Ansdell put forward is that community music therapy [CMT] can encompass both disciplines. He invited respondents to outline how their own work converges with, or diverges from, the ideas in his paper so that we can build "a more inclusive map of this [CMT] territory" (Ansdell 2002). Music therapists whose practice had diverged from conventional music therapy practice needed a new theory because it validated the new and often difficult-to-explain work that they were already doing all over the world (Curtis & Mecado 2004). Stige et al. (2010: 279) also advocated that we should "add to our understanding of community music therapy" since it is still a very misunderstood practice.

In the thirteen years since Ansdell's article there has been more literature written about community music therapy (Pavlicevic & Ansdell 2004; Stige et al. 2010) and discussions are becoming more commonplace both online (see, for example, www.SoundSense.org and www.voices.no) and through continuing professional development (CPD) days and conferences. I have found, however, in my personal experience that there is still a lack of understanding amongst my peers as to what community music therapy is and how it fits in with – or needs to break away from – the theory of conventional music therapy. MPM has enjoyed five European-trained volunteers in Gulu over the years, none of whom knew about community music therapy, but most of whom were not daunted by the differences in practice they encountered, accepting that in this different cultural setting music therapy is bound to 'look' different. However, one volunteer, Ana Navarro Wagner, was so overwhelmed by the guilt of her work with MPM not being 'real' music therapy that on her return to Spain she wrote a Master's thesis about how to reframe her experiences in relation to community music therapy in order to help her understand what she had been doing in Gulu (Navarro Wagner 2013). I thank her for her honest reflections that have also spurred me on to reflect theoretically on the work of MPM.

I, too, have experienced professional guilt about whether MPM is doing 'real' music therapy and, when I began as a newly qualified music therapist, I often felt nervous about 'breaking boundaries' of conventional music therapy. However, since boundaries are being blurred and music therapists are already practising community music therapy I feel I can share my work freely, and unashamedly add my views to the profession's understanding of how things are naturally progressing.

The area of community music therapy is by no means a fixed and defined set of practices and neither should it be because there are as many definitions as there are people to define it. Rykov has a useful idea:

> "Rather than striving for one grand theory of music therapy, music therapy theories must enable us to remain open to ambiguity and the multiplicity of meanings inherent in music and life" (Rykov 2005).

One such theory, or 'key feature' as it is called, that MPM has drawn from and is incorporated into the community music therapy discourse is provided by Gold et al. (2005) and Stige et al. (2010). This key feature of community music therapy called "resource-oriented music therapy" refers to resources as

> "tangible or intangible and may refer to both personal strengths and material goods as well as to symbolic artifacts and relational and social processes that may be appropriated by members of a community" (Stige et al. 2010: 283).

Resource-oriented music therapy is oriented "towards the clients' resources, strengths and potentials, rather than primarily on problems and conflicts, and emphasises collaboration and equal relationships" (Gold et al. 2005).

Community music therapy has been emerging gradually for the last twelve years and this has given music therapists worldwide a theoretical foundation upon which to pin flexible and context-driven practice. I am now able to reflect on my work in Uganda through the framework of community music therapy and music therapy literature.

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therapist' which is, according to the UK standards, protected by the Health and Care Professions Council.

MPM'S WORK

I founded MPM as a peripatetic music therapy service in Gulu in 2008. I started work together with Dutch colleague Jantina Bijpost (whom I thank profusely for her valuable contribution), by offering small, closed music therapy groups for children in SOS Children's Villages, an orphanage where many of the children were traumatically orphaned by the war. The work gained recognition in Gulu and over the years that followed, MPM was invited to offer music therapy in a special needs unit of a school where children often present with autism, Down Syndrome or developmental delay; a boarding school for war-affected children, many of whom had Post Traumatic Stress Disorder (PTSD); a school with a unit for deaf children; a mainstream school in an area badly hit by the rebels and a Remand Home for young offenders.

To start with, the work I did with Jantina looked very much like conventional music therapy:

> "Music therapy has mostly, for the last 30 years, been unduly modest in its aim and applications – restricting its area of help to cultivating intimate relationships with individuals medically classified as physically or mentally sick, and offering such help mostly within the privacy of a therapy room. […] [there has been] the concurrent tendency to individualize both problems and solutions" (Stige et al. 2010: 276).

The work that we did in the beginning focussed on creating intimate relationships with the individuals in a group of six, all of whom had been referred to us as having suffered trauma. The children's problems were considered and we, the therapists, tried to achieve desired therapeutic outcomes for the children. Jantina and I attempted to work within a private therapy room within set time boundaries (as much as was possible in Ugandan culture where spaces are open and people do not keep time). We were the leaders and "sole experts" (Stige et al. 2010: 288) of the group and therefore not considered to be the children's friends, since "music therapy is not usually associated with making friends" (Stige et al. 2010: 287). We were able to run music therapy groups this way because we were analytically trained and therefore able to think about such things as our clients' attachment patterns and internal worlds, and make inferences as to how different aspects of the client's internal world are being presented during therapy and use these inferences to help the client (Priestley 1994). We tried to keep some professional distance from the children we worked with and did not perform to the children or have 'sing-songs' because it has been emphasised that

> "[…] music therapy is a form of psychodynamic therapy, not social therapy, and […] patients might therefore be confused by relating to their therapist as a co-performer, and the transference relationship contaminated as a result" (Maratos 2004: 134-135).

However, as time went on it became clear that there were no local musicians who were willing to give their time for free to play music with the children and when Christmas came around the staff asked me to teach the children some Christmas songs, so I agreed. At the time this made me feel very nervous because I was a newly qualified music therapist and felt I had broken music therapy's rigid – even 'sacred' – boundaries. Stige (2014) was faced with a similar situation as a newly qualified music therapist when a music therapy client (Knut) wanted to play in a marching band. He commented that

> "My music therapy education had not prepared me for this issue, however. Obviously, Knut did not know that music therapists tended to practice with a closed door? All the music therapy practices I knew of focused on change at the level of individual and group, not on community participation" (Stige 2014: 49).

Like Stige noticed when working with Knut, I also saw how much fun the children I worked with were having while singing and how each of them looked visibly more relaxed and happy than they had before. It was around this time that I began to see that this broken community in which I lived and worked needed something from me that conventional music therapy, as I understood it, could not offer on its own. It needed a boost of community spirit that built bridges between former soldiers and their victims; it needed an injection of social skills and lessons in how to play with their peers because children had forgotten how to be carefree. The community also just needed to have fun after 25 years of living in fear!

After six months of working in Gulu, before Jantina and I returned to Europe, we trained a local Ugandan teacher, Betty Acen, to use music as a tool for therapy and counselling. We trained her in a way that enabled her to use music to help children to communicate and play, and taught her some very basic points of analytical therapy such as trying to notice certain responses as the children's transference or projection and to consider the children's attachment patterns. She continued to

run the small music groups in the way which we had taught her, based upon the conventional music therapy model, but adapted them to suit her clients' needs and her abilities to deliver. Over the next year her placements began to change. At the special needs school, there was not enough physical space or staff members available to facilitate small-group sessions so these were stopped. However, the school asked Betty to provide whole-class music therapy sessions for over 40 children. Rather than explaining to the teachers that she could not do it because this is not how music therapy works, she instead took a more 'resource-oriented' approach (Gold et al. 2005; Stige et al. 2010). With this approach, each individual in this new large group brought something of themselves to the group collaborations and together they were empowered through musical activities to transcend the limited expectations that their society had for them. If Betty and I had not allowed our understanding of conventional music therapy to draw from the community's needs, then the special needs school would not be receiving any form of music whatsoever since what MPM does there has gone beyond the boundaries of conventional music therapy. As a result, MPM is following Powell's (2010) lead by helping people to make music together and providing new experiences for people which, in turn, enrich their lives and that of the institution.

Whilst spending time with the teachers and students at the special needs unit I came to realise that they were feeling disempowered due to a lack of respect for their work from parents and even colleagues. Having MPM come alongside the teachers and offer them encouragement through the work with the children, we found that other children in the school were beginning to at least notice and at most have some respect for the disabled children. MPM also demonstrated new ideas that could help to inspire their teaching: it is important for a community music therapist to work with the community, addressing their needs and concerns, and not just to assume that a physical or geographical presence within the community is enough. The Ugandans I worked with would have soon dismissed me if I had not tried to assimilate with their culture and ideas; learning local greetings and ways of relating to each other was as important as the musical ideas I brought. Aasgaard (in Ansdell 2002) stated that his role as a music therapist in palliative care institutions was "to improve the institutional quality of life", which is what we should all, as music therapists or community music therapists, aspire to do, since many of the people with whom we work spend their lives in an institution, which may be the only community they experience. This means that we cannot always work "at the end of a corridor, outside the perimeter of the [institution]" (Maratos 2004: 134) because our work needs to be within the hub of the community in order that we may get a feel for what is of best use for that community.

Special unit for deaf children

In January 2012, MPM employed an art counsellor, Vincent Okuja, to work alongside the music counsellor and to add another string to MPM's bow, offering a wider range of creative therapies to the children MPM worked with.[5] Vincent joined Betty at the unit for deaf children at Laroo Primary School where MPM has run closed groups for around six children since 2010. The children have art and music therapy in a semi-closed setting but the staff members are encouraged to join the groups partly for their own interest and understanding and partly to help Betty and Vince translate sign language. The children also took part in a presentation at a workshop to the parents about music and art therapy where they performed some songs and role-plays for the parents. The aim of this was to help the parents understand what music and art therapy is about and also to learn new ideas about how to communicate with their children.

The idea of performance is another 'key feature' of community music therapy (Stige et al. 2010) but does not mean that performances have to happen in the Western sense of having an audience and a traditional concert environment; rather, by making music, members are performing to each other and therefore revealing themselves to one another. Wood (2006) sets out a model of community music therapy processes that he calls "The Matrix", which includes performance projects and workshops[6]. His view is that people are interconnected therefore

[5] I had read about a case in the Netherlands with Mohammed, a man who had participated in sociotherapy, psychomotor therapy, music therapy and art therapy concurrently (Zwart and Nieuwenhuis 1998). Each of his therapists liaised with each other in order to offer the best help to Mohammed and I was interested to see how art and music could similarly work together for the benefit of the children in Gulu.

[6] Also included in Wood's matrix theory are the processes of individual music therapy, group music therapy, ensembles, concert trips, tuition and music for special occasions although he recognises that each different music therapist may have his or her own variation of processes.

music therapy should also be interconnected.

> "A music therapist can identify the most appropriate formats of music therapy for their client, and be confident that their musical work is part of an interconnected matrix of musical possibilities that has its own safety and rigour" (Wood 2006).

I came to realise that using performance and workshops in MPM's work with the children in the deaf unit, together with their parents and guardians, was a valid and extremely useful way of using music therapy in a community context. In Elefant's (2010) description of her work with children with special needs, she explains that as the children were making music, the staff members were also in the room listening. This brought a sense of performing even though the children were simply making music in the moment. She describes how the children would "glance back at them [the staff members] as if saying 'did you hear me play? Aren't you proud of me?'" (Elefant 2010: 65).

During my time of working in Ugandan schools I have noticed that although the government is trying to implement education for children with special needs[7], there is generally very little value put on these children by teachers and even their own parents. In one case, a deaf girl at the unit for deaf children had been abandoned by her parents and was being brought up by a kindly neighbour. Although there are some teachers who truly take an interest in the children and show genuine care and concern, I also see far too often the children being ignored by the underpaid teachers and they are left to wander around outside the classroom and not encouraged to join in with learning. However, the deaf children in the unit were proud to perform to their carers and show them what they are capable of. They were also happy to have the staff members in sessions with them so that they could be truly seen – their true selves being revealed as they play music or create art.

This openness of the content of therapy sessions through performance is uncharacteristic of conventional music therapy, but it does not mean that it never happens. Ansdell (2005) cites one music therapy client, 'David', with whom he performed at the end of David's therapy. Ansdell saw this performance as "the successful outcome of the individual music therapy process" but whilst reflecting about the therapy with David twelve years later David told Ansdell that this performance had been a highlight of his therapy and Ansdell realised that David considered central something that he himself had thought marginal.

The work happening in the deaf unit of the school in Gulu is also cultivating "the interplay of bonding and bridging" (Stige et al. 2010: 286). The bonding part of the process is to develop relationship ties within the group itself; the bridging part involves reaching out to another community in order to create a 'bridge' for the purpose of uniting the groups. In this situation the deaf children came together as a community and reached out to the parents and others in the wider community outside of the school. Pavlicevic states that this 'bridging' aspect "enables the children to address their elders in a way that would be unthinkable in daily life" (Stige et al. 2010: 286) so when the children in the deaf unit sang songs to their elders, they were able to sing messages such as how you should not give up on children because they are deaf, which is a message they may not have been able to either put into words or even deliver to their elders outside of signed-singing or art.

Remand Home

The work at the Remand Home has not strayed too far from conventional music therapy in that there is confidentiality within the group, some boundaries of time and space and an emphasis on analytical therapy. Ideas for session themes come from the young people, as well as from the therapists, as generated in group discussions during the therapy sessions. As with conventional music therapy, sessions begin and end at set times and usually take place within a set physical boundary and the therapist is not 'on call' to help with things that happen outside of those time or space boundaries.

However, the Ugandan culture offers a different perspective on boundaries (Byakutaaga 2006), and does not have the same ideas about there being a difference between personal and professional boundaries. For example, people often live in tightly-knit communities where they know each other more intimately and there are usually more tangled webs of relationship where cousins, aunts, uncles, brothers and so on live in a closer proximity both physically and emotionally. Added to this is the difficulty of travel in northern Uganda meaning that people often live within walking or cycling distances of their work and therefore can be living in close proximity to their clients, who then see them going

[7] See Ugandan Ministry of Education and Sports, Special Needs and Inclusive Education Department: www.education.go.ug/data/smenu/15/Special%20Needs%20and%20Inclusive%20Education%20.html

about their day-to-day lives. Some traditional models suggest a therapist's professional boundaries may be broken down if she sees a client walking down the road and he wants to stop for a chat, or the client sees where the therapist shops, who they live with and where they spend their social time.

There was one occasion in the Remand Home where these lapsed boundaries served the MPM counsellor, Betty, well so that she could help one of the boys in the Home. A young boy was having difficulty rebuilding his relationship with his father, with whom he had fallen out after the father reported him to the police for illegal behaviour and had him sent to the Remand Home. The boy had been in the MPM music therapy sessions for some weeks during which time Betty began to learn about his situation. She offered to help him by going to meet the boy's father to see if she could help to reunite the father and his son. Over some weeks Betty helped the boy to reconnect with his father even though it was outside of the boundaries of the music therapy sessions.

This crossing of boundaries does not usually happen in conventional music therapy, with the exception that music therapists may work within a wider multi-disciplinary team who may help to follow up certain situations. With the proviso that the music therapist is following the professional conduct required by her post, such as child protection protocols or working within a multi-disciplinary team, it is my view that community music therapists should be allowed to work beyond the boundaries of physical time and space that conventional music therapy (as well as institutions themselves) has put up. In community music therapy there is usually some sort of 'outreach' involved and "there is something more at stake, then than just adding a little unity and fellowship to a standard conception of individual of group music therapy" (Stige et al. 2010: 285).

DISCUSSION

In its early professional years, conventional music therapy needed to have "clear and rigid boundaries based on theoretical principles" as an "attempt by the music therapists to be taken seriously and accorded some status and position within the system" (Maratos 2004: 135). The professional guidelines made sure that music therapy was not misunderstood or misused (for example, some people may believe that music therapy is a medical intervention). However, once music therapy in the UK had received this acceptance and registered courses and regulations were approved by the Health and Care Professions Council, it felt to some as though it had become a closed and inflexible profession (Quin 2014). Now that conventional music therapy (at least in the UK) is secure in its professional status music therapists have started breaking through – or at least repositioning – the walls that protect it professionally from change and opening up the profession to any type of music-making that enables music therapists to "work to accomplish personal change [and be] […] challenged to accomplish social change" (Curtis & Mecardo 2004).

In the early years of starting MPM, I sought advice from UK-based charity Music as Therapy International (MasT), which works in several countries around the world and introduces their local partners to basic music therapy techniques drawn from the UK-model of conventional music therapy through skill-sharing (demonstration in practice). MasT freely accepts, (and even encourages) local ownership of these new skills meaning that each place can adapt the way they practise according to the needs of the country, the culture or the institution in which they are working. MasT 'allows' the local partners to continue to use the term 'music therapy' believing that it can be adapted to suit peoples' needs whilst still essentially being music therapy. I am grateful to MasT for standing with me in my own exploration of how music therapy could be adapted in northern Uganda. I am also pleased that they still use the term 'music therapy' and have not felt the need to modify it or apologise for it because MasT simply accepts that music therapy can be a flexible medium that does not have to stick within rigid professional boundaries. The British Association of Music Therapy (BAMT) had its first conference in February 2014 and took delight in the coming together of music therapists and researchers from many different backgrounds to "share practice, research and celebrate the transformative power music therapy has to play in enriching lives" (BAMT 2014). The BAMT Chair Donald Wetherick introduced the conference in this way:

> "Music therapy is simply too diverse a field to define simply and its richness comes from this overlap between music and the many different fields in which music therapists work. What unites us is precisely our concern with this overlap between 'music' and 'therapy', and all the various subtleties those two words contain" (Wetherick 2014: 15).

This leads us to understand that the term 'music

therapy' can legitimately contain a range of ways of working that might not have been imagined when Ansdell wrote his *Winds of Change* article in 2002. Ansdell (2014) recently wrote a paper commenting on his 2002 article that gives a useful summary of community music therapy's journey so far:

> "CoMT has functioned as a 'trojan paradigm': smuggling into an increasingly reductionist, individualized and medicalized culture of treatment and care a more flexible ecological understanding of the complex relationships between music, people, health, illness and well-being" (Ansdell 2014: 11).

MPM joined this same journey in 2008, from attempting to practise conventional, individualised music therapy in a culture where it is not always appropriate, through a few years of guilt, confusion and blurred boundaries, until it reached the point it is at today of being firmly rooted in relationship with communities, in the freedom that community music therapy offers.

But community music therapy is not at its conclusion yet. As Stige (2014: 52) writes:

> "What I have tried to contribute seems to have formed one little creek that eventually ran into the big river that today constitutes CoMT internationally. Where will the river flow from where we are today? We do not know the landscape of tomorrow, so it is of course hard to predict".

Where will MPM be and what will it be doing tomorrow? I cannot know exactly, but I do know that it will be freely serving its community using music (and creative arts in general) in the best way it can.

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